MONTANA STATE PRISON
HEALTH SERVICES OPERATIONAL PROCEDURE

Procedure No.: MSP HS A-08.0	Subject: **COMMUNICATION ON INMATE HEALTH NEEDS**
Reference: NCCHC Standards: P-A-08 and P-G-02, 2014. MSP HS G-02.0 Inmates with Special Needs, MSP HS A-08.1 Housing of Inmates with Mental Disorders, MSP HS A-08.2 Medical Clearances for Inmate Transfers to Contract Facilities	Page 1 of 2 and 2 attachments
Effective Date: November 1, 2010	Revised: June 1, 2017
Signature / Title: /s/ Cindy Hiner / Health Services Manager	
Signature / Title: /s/ Tristan Kohut, D.O. / Medical Director	

I. PURPOSE

To provide guidelines and procedures to ensure health care staff communicate with general facility staff correctional staff regarding any significant health needs that should be considered in decisions regarding an inmate's housing, work, programming, and disciplinary management in order to preserve the health and safety of the inmate, other inmates, and/or staff.

II. Definitions:

Health Status Report (HSR) – the document used to identify and communicate to facility staff any accommodations or restrictions to an inmate's housing, movement, work or programming related to his health needs.

Special needs patient – those with health conditions that require regular care (i.e. adolescence, developmental disability, frail or elderly patients, physical disabilities including sight and hearing impairments, and serious mental health needs. This may also include patients with recent hospitalizations or ER visits.

Treatment plan – a series of written statements specifying a patient's particular course of therapy and the roles of qualified health care professionals in carrying it out.

III. PROCEDURE

A. General Requirements

1. Health care staff will notify facility custody or administrative staff regarding inmates who require accommodations based on: chronic illness, dialysis, adolescents in adult facilities, communicable diseases, physical disability, terminal illness, unique medication modalities, frail or elderly, mental illness or suicidal, developmental disability, suspected victims of physical/sexual abuse, or other health conditions requiring arrangements for housing, movement, work or other program activities related to their health needs.

2. A Health Status Report (HSR) is completed by a provider/nurse when he/she identifies a health condition(s) during the initial health assessment or for new health condition(s) discovered during subsequent exams which results in the need for:
    1. further diagnostic procedures;
    2. specialty consults;
    3. activity limitations;
    4. medical equipment or supplies
    5. facility restrictions or special housing requirements; or

6. other special needs or work restrictions.

The provider/nurse will refer to the *HSR Criteria Table* prior for finalizing any HSR.

3. When an identified health condition is resolved or stabilized a provider/nurse will institute a change in an existing restriction.

4. In general, the notification will be via an HSR form, copies of which will be filed in the medical chart and provided to the inmate and to staff who operate the inmate's housing unit (a copy should be placed in the inmate's mini-file.

5. The white copy of the completed HSR form is to be placed in the inmate medical chart. The yellow copy is for the inmate. The pink copy of the HSR form is to be forwarded to the unit manager of the appropriate unit for entry into the OMIS system and placement into the inmate's mini-file. Entries will include pertinent information, restrictions, special allowances etc. but not medical diagnosis.

6. Medical records staff will enter work restriction data on the adult Offender Management Information System (OMIS) database. Entries will be based upon initial health assessment information and subsequent work status changes / updates generated by an HSR.

7. Notification for intra-facility moves occurs via the Institutional Transfer form (see attachment B in MSP HS A-08.2) and the medical clearance system.

8. Mental Health clinicians will share pertinent information with the facility administrator regarding inmate mental health needs.

9. The Infirmary Special Needs Committee will review complex inmate cases and requests for restrictions/accommodations from housing unit staff, ADA staff, and administrators at its regular meetings (*see HS G-02.0, Inmates with Special Health Needs*).

IV. CLOSING

Questions concerning this operational procedure will be directed to the Health Services Manager.

V. ATTACHMENTS

HSR Criteria Table	attachment A
HSR Request form.docx	attachment B

HSR	Indications/Diagnosis	Documentation	Comments
Ace wrap	Sprain, Strain	Edema	Limited to 8wks.
Ankle brace	Ligament Laxity/severe instability	Exercise, rehab program compliance & failure	Providers discretion
Bottom bunk	Seizure disorder, W/C Bound BKA, AKA, Walker	cc seizures, seizure med.	
Cane	Special Needs Committee only		
Catheter supplies	BPH, CA, Neuro Bladder		
Cotton blanket	Wool allergy	Wool patch test	Test results recorded on a treatment sheet.
CPAP	Sleep apnea	Pos. sleep study	CPAP at intake
Crutches	Sprain, strain, FX	X-ray results, swelling, eccymosis, anomaly	Limited to 8wks.
Diet	Not indicated		Order written for specific diet
Dressing material	Active wound		Limited to 8wks.
Eating utensils	Special Needs Committee only		Only by OT, PT
Egg crate mattress	Hx pressure ulcer and wheelchair bound		
Elbow sleeve	Not indicated		
Extension cord	Not indicated		
Extra blanket	Not indicated		
Food Allergy	Not indicated		Order written, diet sheet to Kitchen
Eye glasses	Poor vision		Optometrist or intake glasses
Gloves	Wheelchair bound	Self propels	Cannot have an inmate worker
Hearing aid	HOH	Audiogram	Intake HA or sees audiologist
Heating pad	Sprain strain infection	Admit note	Only used on patients admitted to the Infirmary
Ice	Sprain strain	Edema	Limited to 3d
Knee sleeve	Ligament Laxity/severe instability	Exercise, rehab program compliance & failure	Providers discretion
Laundry	Not indicated		
Lay-in	Acute illness or injury		Limited to 2wks.
Light duty	Injury		Limited to 8wks.
Long sleeve shirt	Rash	Photosensitive med., no alt tx available	
Lower tier cell	W/C bound BKA, AKA, Walker		
Meals in cell	Not indicated		
Nebulizer	Special Needs Committee only	COPD/Lack of ability to use MDI	
Neck brace	Fx	X-ray results, tx plan	Limited to 8wks.
Orthotics	Not indicated	Orthopedic consult	
Ostomy supplies	Ostomy		
Oxygen	Hypoxia	sats < 88%	
Pillow	Not indicated		
Prosthesis	BKA, AKA, Ocular		
Sandals	Edema, infection, drsg.		Limited to 8wks.
Scissors	Not indicated		
Shirt with buttons	Not indicated		
Shoes	Hx Diabetic foot ulcer	Podiatrist consult	
Shoulder immobilizer	Fx, dislocation	X-ray	Limited to 8wks.
Shower chair	W/C bound, BKA, AKA		

HSR	Indications/Diagnosis	Documentation	Comments
Single cell	Not indicated		If contagious needs to be in infirmary
Sling	Sprain strain		Limited to 2wks.
Snacks	Type One diabetic		At HS only.
Spacer	Asthma, COPD	Rx for inhaler	
Splints	Sprain strain		Limited to 8wks.
Straws	Not indicated		
Suspenders	Not indicated		
Ted hose	Dep edema, CHF, PVD, coagulo		
Thermals	Not indicated		
Towels, extra	Not indicated		
Truss	Hernia		
Urinal	W/C bound	Unable to get up without assist. of other.	
Urinary pads	Incontinence		
Walker	Special Needs Committee only		
Wedge	CHF, PVD/ulcers, Barretts		Must be severe on Max. Med. Tx.
Wheel chair	Special Needs Committee only		
Work category	Not indicated		Order written for category, to med records.
Wrist splint	Pos. Phalen, tinel, finklestein or	Exercise, rehab program compliance & failure	
Writing utensils	Not indicated		

All HSR's should be good for one year unless otherwise indicated.
Exceptions to this guideline must go through the Special Needs Committee.

MONTANA STATE PRISON

HSR FORM

Inmate Name: _____ Inmate #: _____

Age:_____ Housing location:_____ Date Requested ___/____/____

Inmates current work status and work location:_____

☐ Initial Treatment ☐ Renewal ☐ Supplies Issued

PROVIDER/NURSE MUST COMPLETE

HSR Requested: _____ Duration:_____

Directions:_____

_____

Prescriber:_____

Reason HSR is necessary, check all that applies:

☐ Inmate strictly meets criteria for HSR

☐ Nursing protocol treatment

☐ Alternative treatments have been explored and found ineffective

☐ Other – Explain:_____

_____

_____

Nurse Signature:_____ Date: ____/____/____

PA/NP/Physician Signature:_____ Date: ____/____/____

Comments:

Quality Assurance Manager

☐ Approved as Requested ☐ Approved with Modification ☐ Denied until Further Review

Explanation:_____

_____

_____

Name:_____

Signature:_____ Date: ____/____/____

Instructions:

1. Requests will be reviewed and returned within 48 hours. Requests received after 11:00 a.m. on Fridays will be reviewed on the next working business day.
2. If HSR's are needed **ASAP** such as lay-ins, dressing supplies, braces, crutches or ice, the form will be filled out and the supplies provided. A copy is then placed in the Quality Assurance Manager's mail box for review.